MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5993

5979 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12 — LENGTH OF STAY (in this place) 3 Yrs.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1003 Bell Ave., X	STREET ADDRESS (If rural give location) 1003 Bell Ave.,

3. NAME OF DECEASED: (Type or Print) (First) BEATRICE (Middle) GAFFORD (Last) ANDERSON

4. DATE OF DEATH: (Month) 6 (Day) 4 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 25, 1879

9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Ludlow Gafford

14. MOTHER'S MAIDEN NAME: Caroline Phifer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mr. Harry L. Gafford, Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

Immediate cause (a) Carcinoma of Liver — Interval Between Onset And Death: 1 yr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Carcinoma of Breast (rt.) — 5 yrs.

DUE TO (c) Carcinoma of Breast (left) — 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 1949 1951

19b. MAJOR FINDINGS OF OPERATION: Carcinoma

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to June 4, 1954, that I last saw the deceased alive on May 26, 1954, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) Thomas B. Mann M.D. — ADDRESS Salisbury Md — DATE SIGNED 6/5/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 6/8/54 — NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery — LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR 6-7-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR The Hill & Johnson Co. — ADDRESS Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05994

6013

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R. D. # 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): R. D. # 5

3. NAME OF DECEASED: (First) ADA (Middle) MAY (Last) ARCHIBLN

4. DATE OF DEATH: (Month) JUNE (Day) 6 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Aug. 31, 1885

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months 9 Days 5 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Camden New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Chew

14. MOTHER'S MAIDEN NAME: Susan Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Charles H. Binsel (Son-In-Law) 447 E. Elm Ave. Woodbury, New Jersey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (INTERVAL BETWEEN ONSET AND DEATH)

Immediate cause 422.1 (a) Cardiac Failure

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Ch. Cardio-vascular Disease

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-6, 19 54, to 6-6, 19 54, that I last saw the deceased alive on ....., 19....., and that death occurred at 10:20 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Wm B. Smith MD Salisbury, Maryland June 6 1954

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 10, 1954	New Camden Cemetery	Camden, New Jersey

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-7-54	Mary W. Holloway	HOLLOWAY & COMPANY	SALISBURY MARYLAND

Walter R. Holloway

RECEIVED
JUN 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5995

5980

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Hill Private Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Church Creek 09X-2
STREET ADDRESS (If rural, give location) P.O.

3. NAME OF DECEASED: (Type or Print) (First) ASPLEN (Middle) (Bertie C. Asplen) (Last)

4. DATE OF DEATH: (Month) June (Day) 27 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	not known	Aprox 75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not Known	Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Salisbury, Maryland Spring Hill Convelesent Home;

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio vascular renal disease

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19.54, to June 27, 19.54, that I last saw the deceased alive on June 26, 19.54, and that death occurred at 6:40 P. m., from the causes and on the date stated above.

SIGNATURE Alma Lucky M.D. (DEGREE OR TITLE) ADDRESS Salisbury Md DATE SIGNED 6-27-54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-29-1954	Old Trinity Cemetery	Church Creek, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
7-6-54	John Mace by Mrs. Mary W. Holloway	LeCompte Funeral Service Cambridge, Maryland

RECEIVED
JUL 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6014 CERTIFICATE OF DEATH

05996 Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury | LENGTH OF STAY (in this place) 54 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eden Rt. 2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wico.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) Eden Rt. 2

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) WILLIAM (Last) BOUNDS

4. DATE OF DEATH: (Month) 6 (Day) 13 (Year) 1954

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: FEB. 12, 1875 | 9. AGE last birthday: 79 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jones Bounds | 14. MOTHER'S MAIDEN NAME: Ann Maria White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT & ADDRESS: Mrs. Belle Bounds-Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) DEHYDRATION + MALNUTRITION — Interval Between Onset And Death: 18 DAYS

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) CEREBRAL VASC. ACCIDENT — 18 DAYS

DUE TO

(c) ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. HYPERTENSION

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1954, to 6-11, 1954, that I last saw the deceased alive on 6-11, 1954, and that death occurred at 4 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Geo. M. Dunn M.D. | ADDRESS Princess Anne Md | DATE SIGNED 6-14-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 6/15/54 | NAME OF CEMETERY OR CREMATORY Salisbury Cemetery | LOCATION (City, town, or county) Salisbury, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 6-14-54 | REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR The Hill & Johnson Co. | ADDRESS George C. Hill

RECEIVED
JUN 16 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 05997

CERTIFICATE OF DEATH

5981 FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A16A

1. PLACE OF DEATH: COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; STREET ADDRESS (If rural, give location) 203 East Locust St.

3. NAME OF DECEASED (Type or Print): (First) TALMADGE (Middle) HENRY (Last) BOWEN

4. DATE OF DEATH: (Month) JUNE (Day) 17 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 15, 1913

9. AGE last birthday: 41 yrs. If under 1 year: Months 1, Days 2; If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (State or foreign country): Rocksboro, North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Bowen

14. MOTHER'S MAIDEN NAME: Mollie (Unk)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) Unk

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Pauline L. Bowen (Wife) 203 E. Locust

18. MEDICAL CERTIFICATION St. Salisbury, Maryland

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Brain injury	1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Subdural hemorrhage	2 weeks
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: 6-4-54

19b. MAJOR FINDINGS OF OPERATION: Subdural Hematoma

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) Farm

(CITY OR TOWN) New Delmar (COUNTY) Sussex (STATE) Del

TIME OF INJURY (Month) 5 (Day) 16 (Year) 54 (Hour) 3 p.m.

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR? Lever of cultivator hit him in face

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE J. L. Rademeyer (Degree or title) ADDRESS N. Division St. Salisbury Maryland DATE SIGNED June 19 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: June 20, 1954; NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park; LOCATION (City, town, or county) (State): Salisbury Maryland

DATE REC'D BY LOCAL REG. 6-20-54; REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY; ADDRESS: SALISBURY MARYLAND

Walter R. Holloway

RECEIVED
JUN 22 1954
BUREAU V. S.

6015 05998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
LENGTH OF STAY (in this place) 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. #1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN SALISBURY
STREET ADDRESS (If rural, give location) Rt. #1

3. NAME OF DECEASED: (Type or Print) (First) Leroy (Middle) Hooper (Last) Brewington
4. DATE OF DEATH (Month) 6 (Day) 13 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Feb. 12, 1886
9. AGE last birthday: 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Ret. Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Albert L. Brewington
14. MOTHER'S MAIDEN NAME: Jennie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-18-4748
17. INFORMANT & ADDRESS: Mrs. Viola Brewington - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Coronary Occlusion	Suddan Death
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Myocardial degeneration	2 yrs.
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none

19a. DATE OF OPERATION: none
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY none
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6-14-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6/15/54
NAME OF CEMETERY OR CREMATORY Shad Point Cemetery
LOCATION (City, town, or county) (State) Shad Point, Maryland

DATE REC'D BY LOCAL REG. 6-14-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Hill & Johnson Co. SALISBURY, Md.
ADDRESS George C. Hill II.

VS. A15A - 5 - 53

RECEIVED
JUN 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05999 Reg. Dist. No. 332

5982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
LENGTH OF STAY (in this place) 2 yrs 2½ mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Florence (Middle) (Last) Brown

4. DATE OF DEATH: (Month) June (Day) 22 (Year) 1954.

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Unknown

8. DATE OF BIRTH: 1879 ?

9. AGE last birthday: 75? yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown (If Yes, give war or dates of service) --

16. SOCIAL SECURITY NO.: --

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) CNS. Syphilis, paretic type — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart disease — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1, 19 53, to 6-22, 19 54, that I last saw the deceased alive on 6-22, 19 54, and that death occurred at 10 25 p.m., from the causes and on the date stated above.

SIGNATURE Dr. V. Guerriman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head Hospital, Salisbury, Md. DATE SIGNED 6/22/54

23. BURIAL, CREMATION, REMOVAL (Specify): Removal

DATE THEREOF June 25 1954

NAME OF CEMETERY OR CREMATORY Woodlawn Rd

LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REG. 6-25-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Dorsey M. West ADDRESS

RECEIVED
JUN 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18 1130 Pm

6016 CERTIFICATE OF DEATH

Dr. Kuhlman

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico Co. Md. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. Wicomico Co. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
STREET ADDRESS (If rural give location): Rural.

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) W. (Last) Brown

4. DATE OF DEATH: (Month) June (Day) 13 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov. 9. 1878.
9. AGE last birthday: 75. yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farmer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Sharptown Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. L. Brown
14. MOTHER'S MAIDEN NAME: Rachel Gaines.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 213-16-8429
17. INFORMANT & ADDRESS: Marada Brown - wife.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

X Immediate cause (a) Arterial Hemorrhage — Interval Between Onset And Death: 7 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 1954, to June 13, 1954, that I last saw the deceased alive on June 13, 1954, and that death occurred at 10:30 PM, from the causes and on the date stated above.

SIGNATURE: H B Kuhlman (Degree or title) M.D. ADDRESS: Sharptown Md DATE SIGNED: 6/14/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: June 17. 1954
NAME OF CEMETERY OR CREMATORY: Sharptown Cem.
LOCATION (City, town, or county) (State): Sharptown Md.

DATE REC'D BY LOCAL REGISTRAR: 6-14-54
REGISTRAR'S SIGNATURE: Mary W. Holloway
24. FUNERAL DIRECTOR: Booker M Cuesh ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

RECEIVED
JUN 16 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6001

5983 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

MARYLAND

LENGTH OF STAY (in this place) 3½ years

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Maryland

STREET ADDRESS (If rural, give location) Water Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Samuel	-	Cannon	June	19	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Single	July 2, 1886	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Unknown	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Unknown	Julia Sidney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unknown --	212-16-5799	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Thrombosis	10 mi.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis	8 years
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 11.1, 1953, to 6.19, 1954, that I last saw the deceased alive on 6.19, 1954, and that death occurred at 10'30 P.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Dr V Sherman	M.D.	Deer's Head State Hospital, Salisbury	6/19/54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	June 23 1954	Centennial Bd	Balto Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-25-54	Mary M. Holloway	Bowker & Veach	

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 23 1934
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06002

CERTIFICATE OF DEATH

5984

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deerhead State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colona R.F.D. #1
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) H. (Last) Caudill

4. DATE OF DEATH: (Month) June (Day) 13 (Year) 1954

5. SEX: M **6. COLOR OR RACE:** W **7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): S. **8. DATE OF BIRTH:** August 5, 1922 **9. AGE last birthday:** 32 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembler **10b. KIND OF BUSINESS OR INDUSTRY:** ~~Unknown~~ Aircraft **11. BIRTHPLACE** (State or foreign country): Maryland **12. CITIZEN OF WHAT COUNTRY?** USA

13. FATHER'S NAME: Caudill Howard **14. MOTHER'S MAIDEN NAME:** Ellen - Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No Unk. (If Yes, give war or dates of service) **16. SOCIAL SECURITY NO.:** ? **17. INFORMANT & ADDRESS:** Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Second + Third degree Burns of — INTERVAL BETWEEN ONSET AND DEATH: 7 weeks.

DUE TO

Antecedent cause(s) (b) skin (Extensive)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus ?

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) Hospital (CITY OR TOWN) Salisbury (COUNTY) Wic. (STATE) Md.

TIME OF INJURY (Month) 4 (Day) 18 (Year) 54 (Hour) A.M. **INJURY OCCURRED** While at work ☐ Not while at work ☒ **HOW DID INJURY OCCUR?** P+ set bed on fire c̄ cigarette.

22. I hereby certify that I attended the deceased from 6-22, 1951, to 6-13, 1954, that I last saw the deceased alive on 6-12, 1954, and that death occurred at 8:45 A.m., from the causes and on the date stated above.

SIGNATURE B J Gore MD (DEGREE OR TITLE) ADDRESS Deerhead St Hospital DATE SIGNED 6-13-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial **DATE THEREOF** June, 16, 1954 **NAME OF CEMETERY OR CREMATORY** Mt. Zion, **LOCATION** (City, town, or county) Bel Air, R.D. Harford (State) Md.

DATE REC'D BY LOCAL REG. 6-18-54 **REGISTRAR'S SIGNATURE** Mary W. Holloway **24. FUNERAL DIRECTOR** Howard K. Mc Comas & Son, Abingdon, Md., ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
JUN 21 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06003

6017 CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar X
LENGTH OF STAY (in this place) 73 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 400 E.State St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
STREET ADDRESS (If rural give location) 400 E.State

3. NAME OF DECEASED: (Type or Print) (First) Herman (Middle) Winfield (Last) Culver

4. DATE OF DEATH: (Month) June (Day) 9 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Mar 5,1881
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Delmar
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winder W.Culver
14. MOTHER'S MAIDEN NAME: Martha Gillis

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY No.: 716-03-1654
17. INFORMANT & ADDRESS: Clara Culver, Delmar, Del.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral embolism, right — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) arteriosclerotic heart disease with auricular fibrillation — 7 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to June 9, 1954, that I last saw the deceased alive on June 9, 1954, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature], Md. ADDRESS Delmar Md. DATE SIGNED 6-12-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6-12-54
NAME OF CEMETERY ~~OR CREMATORY~~ Mt Olive
LOCATION (City, town, or county) (State) Delmar, Del.

DATE REC'D BY LOCAL REGISTRAR June 12 1954
REGISTRAR'S SIGNATURE Harry E. Hudson Sr.
24. FUNERAL DIRECTOR W S Mann Co. ADDRESS Delmar, Del

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06004

5985 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland. COUNTY Somerset.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Novella (Middle) (Last) Dashields
4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1954.
5. SEX: Female
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Mar. 30, 1930
9. AGE last birthday: 24 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Johnson
14. MOTHER'S MAIDEN NAME: Laura Dorman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Charles Dashields

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Exsanguination
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Post partum hemorrhage
DUE TO
(c) Premature Separation of Placenta. Afibrinogenemia

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 .., to ....., 19 ....., that I last saw the deceased alive on ....., 19 .., and that death occurred at 8:15 AM., from the causes and on the date stated above.
SIGNATURE (Degree or title) Wm B Smith M.D. ADDRESS Salisbury Md. DATE SIGNED 6-2-54.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 6-6-54 NAME OF CEMETERY OR CREMATORY Greenwood LOCATION (City, town, or county) Princess Anne, Md (State)
DATE REC'D BY LOCAL REGISTRAR 6-3-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Charles H Ward ADDRESS Marion Sta Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
JUN 7 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6005

5986

Dr. Larmore - Delmar Nel. **CERTIFICATE OF DEATH** Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) Cherry Way Route #5.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
CLARENCE	RAYMOND	DAVIS	June	10	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Oct. 18, 1898	55 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Clerk	Grocery Store	R.D. # Delmar Delaware	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Davis	Mary Benson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
W.W. # 1 Army		Mrs Naomi Watson Davis (Wife) R.D. # 5 Cherry Way Salisbury Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Uremia (renal failure) and	3 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) possible coronary occlusion	unknown
	DUE TO (c) Tuberculosis of remaining kidney	5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
about 1950	nephrectomy for tuberculosis of kidney	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐	Not While At Work ☐	HOW DID INJURY OCCUR?
m.			

22. I hereby certify that I attended the deceased from 4/20, 1953, to death, 19..., that I last saw the deceased alive on 6/9, 1954, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ernest D. Larmore	M.D.	Delmar, Del	6/10/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 13, 1954	Hebron Cemetery	Hebron, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-11-54	Mary W. Holloway	HOLLOWAY & COMPANY	SALISBURY MARYLAND

Walter R. Holloway

RECEIVED
JUN 14 1951
BUREAU V. S.

5987

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06006 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury

STREET ADDRESS (If rural, give location) 317 Boulden Lane;

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frances	Patricia	Davis	6	1	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	Colored	Single	8-13-'45	8 yrs.	9	18		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Child	School Girl	Salisbury, Wicomico Co. Md.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Frank Davis	Lillian Lorraine Leonard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mrs. Lillian Davis, 317 Boulden St. Salis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Brain injury	3/4 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) Salisbury	(County) Wicomico	(State) Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
6	1	54	M.			Hit on head with piece of wire

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H A Radcliffe M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 6/5/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-6-'54	Green Acres Memorial Park	Salisbury, Wicomico Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-5-54	Mary W. Holloway	Mary A. Stewart	324 E. Church St. Salis. Md.

STEWART FUNERAL HOME

VS. A15A - 5 - 53

JUN 8 1954

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 16007

CERTIFICATE OF DEATH

5988

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Quantico
STREET ADDRESS (If rural, give location): R.D. #

3. NAME OF DECEASED (Type or Print): (First) ALTON (Middle) HARRIS (Last) DOWNING

4. DATE OF DEATH: (Month) JUNE (Day) 15 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan 2, 1905

9. AGE last birthday: 49 yrs. — IF UNDER 1 YEAR: Months 5, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Mechanic

11. BIRTHPLACE (State or foreign country): R.D. # 1 Quantico Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Minous Downing

14. MOTHER'S MAIDEN NAME: Lena Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Annabell Downing (Wife) R.D. Quantico Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

816

Immediate cause — (a) Pneumothorax; punctured lung — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Severe laceration of scalp; fractured — DUE TO

(c) ribs; multiple abrasions.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE: accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Salisbury (CITY OR TOWN) Wicomico (COUNTY) Md. (STATE)

TIME OF INJURY (Month) 6 (Day) 12 (Year) 54 (Hour) 5

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS: William H Holloway M.D. N. Division St Salisbury, Md.

DATE SIGNED: June 17 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: June 17 1954

NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park

LOCATION (City, town, or county) (State): Salisbury, Maryland

DATE REC'D BY LOCAL REG. 6-17-54

REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

Walter R. Holloway

RECEIVED
JUN 21 1954
BUREAU V. S.

5989 06008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival Pk. Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Penn. COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Philadelphia
STREET ADDRESS (If rural, give location) 6128 Irving Street

3. NAME OF DECEASED: (Type or Print) (First) Warren (Middle) E (Last) Evans

4. DATE OF DEATH (Month) 6 (Day) 26 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov. 8, 1897
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Bureau Mgr. Marine assn.
10b. KIND OF BUSINESS OR INDUSTRY: Phila Local #13
11. BIRTHPLACE (State or foreign country): Milville, Delaware
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. Evans
14. MOTHER'S MAIDEN NAME: Angie Daisey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Elizabeth W. Evans, Philadelphia, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
4:01
Immediate cause (a) Coronary Occlusion
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden death

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. None
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE L A Rademaker M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6-27-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6/30/54
NAME OF CEMETERY OR CREMATORY Arlington Cemetery
LOCATION (City, town, or county) (State) Landsdowne Penn.

DATE REC'D BY LOCAL REG. 6-26-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Holloway Co. Salisbury Md
ADDRESS Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

JUN 30

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Dr. Saunderson 5990 **CERTIFICATE OF DEATH** 66069 Reg. Dist. No. 332

1 PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) Northwood Drive

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) (Last) Fitzgerald

4. DATE OF DEATH: (Month) June (Day) 27 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 25, 1954

9. AGE last birthday: 0 yrs. IF UNDER 1 YEAR: Months 0 Days 2 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pen. Gen. Hospital Salisbury Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Fitzgerald

14. MOTHER'S MAIDEN NAME: Jeannette Wilkinson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Thomas Fitzgerald (Father) Northwood Drive Salisbury, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ? Pulmonary Hyaline Membrane Disease

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Prematurity (wt 4-2½)

DUE TO

(c)

Interval Between Onset And Death: 2 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/25/1954, to 6/27/1954, that I last saw the deceased alive on June 27, 1954, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert W. Saunderson Jr M.D. ADDRESS Salisbury Maryland DATE SIGNED June 28, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 28, 1954

NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park

LOCATION (City, town, or county) (State) Salisbury Maryland

DATE REC'D BY LOCAL REGISTRAR 6-28-54

REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

2064245302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 30 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06992

5991

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR TOWN) Salisbury
LENGTH OF STAY (in this place) MARYLAND 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deal Island.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Ollie (Middle) (Last) Godwin
4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Colored	Married	Aug 12 1898	55 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): seafood worker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Dredd Island Somerset Co Md
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: William Green
14. MOTHER'S MAIDEN NAME: William Anna Jones

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no			Lorean Harris Dealisland Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

		Interval Between Onset And Death
Immediate cause	(a) uremia	1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Hypertensive Vascular Disease	unknown
	DUE TO (c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-25, 1954, to 6-2, 1954, that I last saw the deceased alive on 6-2, 1954, and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wilbur R. Ellis M.D.		Salisbury Md.	6-2-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 6-1954	John Wesley	Dealisland Somerset Co

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-2-54	Mary W. Holloway	Charles H Ward	Marion Sta Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 7 1954
BUREAU V. S.

5992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06010 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hos. Salisbury

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Gumboro
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) Aubrey (Middle) (Last) Harvey
4. DATE OF DEATH (Month) June (Day) 25 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Colored		May 2, 1920	34 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		West Point, Va.	USA

13. FATHER'S NAME: Willie Harvey
14. MOTHER'S MAIDEN NAME: Ada ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Edna West, Harborton, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Dislocated C6 or 7, fractured 1st vertebra; trans-
DUE TO ected spinal cord. — Interval Between Onset and Death: 4 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDING OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Highway	21c. (City or town) near Pittsville	(County) Wicomico	(State) Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6 21 54 ? M.	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR? Truck turned over

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE F. H. Rodemaker M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6-29-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	6-30-54	Holy Trinity Cemetery	Nr. Pungoteague Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-30-54	Mary W. Holloway	J. Edgar Thomas	Accomac, Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
JUL 6
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06011

5993

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riverside Nursing Home 100

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron
STREET ADDRESS (If rural, give location) R.D. # 1

3. NAME OF DECEASED: (Type or Print) (First) ALEXANDER (Middle) M (Last) HOLLOWAY

4. DATE OF DEATH: (Month) JUNE (Day) 1 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: March 28, 1869
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months 2 Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: On Own Farm
11. BIRTHPLACE (State or foreign country): R.D. Quantico Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Holloway
14. MOTHER'S MAIDEN NAME: Elizabeth Hearn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mr. Francis L. Holloway (Son) Durham N.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma upper end stomach 1 yr.
DUE TO

Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-4, 1954, to 5-4, 1954, that I last saw the deceased alive on 5-11-54, 1954, and that death occurred at 3:55 P.m., from the causes and on the date stated above.

SIGNATURE H. A. Briele M.D. (DEGREE OR TITLE) ADDRESS N. Division St. Salisbury, Maryland DATE SIGNED June 3 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF June 4, 1954
NAME OF CEMETERY OR CREMATORY St Philip Esp. Cemetery
LOCATION (City, town, or county) Quantico, Maryland (State)

DATE REC'D BY LOCAL REG. 6-3-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
JUN 7 1954
BUREAU V. S.

Dr. Lewis

06012

MARYLAND STATE DEPARTMENT OF HEALTH

6018

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH — COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Willards — LENGTH OF STAY (in this place): 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hearns Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Delaware — COUNTY: Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pittsville, Md. R.D.
STREET ADDRESS (If rural, give location): Gumboro - Pittsville Hwy.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Flora D. Holloway
4. DATE OF DEATH (Month) (Day) (Year): 6/18/54 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Mar 25 1872
9. AGE last birthday: 82 yrs. — If under 1 year: Months 2, Days 24 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Hitchens
14. MOTHER'S MAIDEN NAME: Hester Truitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: — —
17. INFORMANT AND ADDRESS: Floyd Holloway - Pittsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis chronic — 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1953, 19..., to 6-18, 1954, that I last saw the deceased alive on 6-18, 1954, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

SIGNATURE: Frank R. Lewis (Degree or title) M.D. — ADDRESS: Willards Md. — DATE SIGNED: 6-18-54.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 6/21/54
NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
LOCATION (City, town, or county) (State): Willards, Md. R.D.

DATE REC'D BY LOCAL REG.: 6-18-54
REGISTRAR'S SIGNATURE: Mary W Holloway
24. FUNERAL DIRECTOR: Wm Howard Wells — ADDRESS: Pittsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 21 1954
BUREAU W. &

5994

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06013 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) All life
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 318 Boulden Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 318 Boulden Lane

3. NAME OF DECEASED: (Type or Print) (First) Maurice (Middle) Lee (Last) Jones

4. DATE OF DEATH (Month) 6 (Day) 21 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Baby
8. DATE OF BIRTH: 12/25/53
9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months 5 Days 26 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Baby
10b. KIND OF BUSINESS OR INDUSTRY: Baby
11. BIRTHPLACE (State or foreign country): P. G. Hospital; Salisbury
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Willie Leggett
14. MOTHER'S MAIDEN NAME: Edna Louise Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Baby (If Yes, give war or dates of service) Baby
16. SOCIAL SECURITY NO.: Baby
17. INFORMANT & ADDRESS: Mrs. Sarah Jones, 318 Bouldan St. Salis. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute fulminating pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Or 3 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY None M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Jas Rademaker M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6/22/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6/23/54
NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park
LOCATION (City, town, or county) (State) Salisbury, Wicomico, Maryland

DATE REC'D BY LOCAL REG. 6-22-54
REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR ADDRESS Mary A. Stewart 324 E. Church Street

10V3151375

STEWART FUNERAL HOME Salisbury, Md.

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the ...s of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 24
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06014

Dr. Beardsley 6019 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Powellville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Willards R.D. # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Powellville
STREET ADDRESS (If rural give location) Willards R.D. # 1

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) JACOB (Last) JONES

4. DATE OF DEATH: (Month) June (Day) 30 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 25, 1874

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months 7 Days 5 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: On Own Farm (Retired)

11. BIRTHPLACE (State or foreign country): Powellville Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hargis Jones

14. MOTHER'S MAIDEN NAME: Emma Adkins

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Hargis Jones (Son) Powellville Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart failure — Interval Between Onset And Death 6 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. prostatic hypertrophy

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1954 to June 30 1954, that I last saw the deceased alive on June 30, 1954 and that death occurred at 10:00 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Earl M. Beardsley M.D. ADDRESS 120 E. Church St. Salisbury, Maryland DATE SIGNED July 2 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF July 3, 1954 NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery LOCATION (City, town, or county) (State) Near Powellville Maryland

DATE REC'D BY LOCAL REGISTRAR 7-2-54 REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

VS. A15

RECEIVED
JUL 6
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

06015

5995 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico Salisbury MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) ✓

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

STREET ADDRESS (If rural give location) 800 South Division St

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) S. (Last) Layfield

4. DATE OF DEATH: (Month) June (Day) 19 (Year) 19 54

5. SEX: male

6. COLOR OR RACE? white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed(?)

8. DATE OF BIRTH: Oct. 14, 1884

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): (?) Retired

10b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory Worker

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Layfield

14. MOTHER'S MAIDEN NAME: Rose Truitt.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Thomas Layfield (Brother) 204 W. Vine St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hepatic insufficiency

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Obstractive biliary cirrhosis

DUE TO

(c)

1260 X

Interval Between Onset And Death: ? ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. - Diabetes mellitus

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -

(CITY OR TOWN) - (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) - m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/26/ 19 54, to 6/19/ 19 54, that I last saw the deceased alive on 6/19/ 19 54, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Malone, M.J. Deer's Head St. Hospital ADDRESS Salisbury Md. DATE SIGNED 6/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 22, 1954

NAME OF CEMETERY OR CREMATORY Parsons Cemetery

LOCATION (City, town, or county) Salisbury (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 6-22-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I M

RECEIVED
JUN 24 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 16016

5996 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) Since 1/22/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital Salisbury, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rehobeth
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Olivia (Middle) Estelle (Last) Mariner

4. DATE OF DEATH: (Month) June (Day) 18 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 12, 1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months 2 Days 6 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Postmistress

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Rehobeth, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard C. Adams

14. MOTHER'S MAIDEN NAME: Susan Beale

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT & ADDRESS: Patient when admitted

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cor. Pulmonale DUE TO — Interval Between Onset And Death: 2yr

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) pulmonary Tuberculosis Arrest DUE TO — 6yr

(c)

002X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/22/50, 19.., to 6/18/54, 19.., that I last saw the deceased alive on 6/18, 1954, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. Supt. ADDRESS Salisbury, Md. DATE SIGNED 6/16/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 6/20/54 NAME OF CEMETERY OR CREMATORY Rehoboth Baptist LOCATION (City, town, or county) Rehoboth, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 6-21-54 REGISTRAR'S SIGNATURE Mary W. Holloway 24. FUNERAL DIRECTOR Henry H. Watson ADDRESS Pocomoke Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ...ce is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 23 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06017

5997

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Salisbury~~ Eden
STREET ADDRESS (If rural give location) R. D. # 1

3. NAME OF DECEASED: (Type or Print) (First) SILVA (Middle) MARIE (Last) McGrath

4. DATE OF DEATH: (Month) June (Day) 19 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 19, 1954

9. AGE last birthday: 0 yrs. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 16

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pen. Gen. Hospital Salisbury

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Norris Samuel McGrath

14. MOTHER'S MAIDEN NAME: Maryland Minnie Elizabeth Riggen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mr. Norris Samuel McGrath (Father) R.D. # 1 Eden, Maryland (Near- Salisbury, Md.)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Non-expansion of Lungs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General fetal abnormalities

DUE TO

(c) Monster formation - Microcephaly

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1:38 6/19 1954, to 6/19, 1954, that I last saw the deceased alive on 6/19, 1954, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm B. Smith M.D. ADDRESS N. Division St. Salisbury Maryland DATE SIGNED June 19 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 21, 1954

NAME OF CEMETERY OR CREMATORY Parsons Cemetery

LOCATION (City, town, or county) (State) Salisbury Maryland

DATE REC'D BY LOCAL REGISTRAR 6-20-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

2064211324

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6018

6020 CERTIFICATE OF DEATH

Reg. Dist. No. 332

Dr. Insley

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Salisbury
LENGTH OF STAY (in this place): 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R. D. # 4 X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): R. D. # 4

3. NAME OF DECEASED: (Type or Print) (First) ANNITTA (Middle) (Last) MERRITT

4. DATE OF DEATH: (Month) JUNE (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 13, 1871

9. AGE last birthday: 82 yrs. — IF UNDER 1 YEAR: Months 10 Days 17 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Own Home

11. BIRTHPLACE (State or foreign country): Jersey City New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (unK) Fischer

14. MOTHER'S MAIDEN NAME: Christine Lighthiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Charles F. Merritt (Son) R.D. # 4

18. MEDICAL CERTIFICATION — Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Carcinomatosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma breast.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 26, 1954, to June 30, 1954, that I last saw the deceased alive on , 19 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.

SIGNATURE Walter R. Holloway (Degree or title) ADDRESS East Main St. Salisbury, Md. DATE SIGNED July 2 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF July 2, 1954 — NAME OF CEMETERY OR CREMATORY Parsons Cemetery — LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR 7-2-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY MARYLAND — ADDRESS

Walter R. Holloway

RECEIVED
JUL 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 66019

6021 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bivalve
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bivalve
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Elsie (Middle) Myrtle (Last) Messick

4. DATE OF DEATH: (Month) June (Day) 10 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 20 Mar. 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR Months 2 Days 20 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired). Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country). Bivalve, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Jarrett

14. MOTHER'S MAIDEN NAME: Sarah Larmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Earl Messick, Bivalve, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Truncation. — Interval Between Onset And Death: 3 weeks.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Carcinoma of Cecum Ascending Colon. — 1 year.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3, 1954, to 6/10, 1954, that I last saw the deceased alive on 6/10, 1954, and that death occurred at 12 35 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) Richard H. Saunders, M. D. ADDRESS Pocomoke, Md. DATE SIGNED 6/10/54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried — DATE THEREOF 6/12/54 — NAME OF CEMETERY OR CREMATORY Bivalve Cemetery — LOCATION (City, town, or county) (State) Bivalve, Maryland

DATE REC'D BY LOCAL REGISTRAR 6-10-54 — REGISTRAR'S SIGNATURE Mary W. Holloway — 24. FUNERAL DIRECTOR Cornelius H. Messick, Bivalve, Maryland — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 14 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6020

6022 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parsonsburg
MARYLAND LENGTH OF STAY (in this place): About 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: At home - Route # 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parsonsburg
STREET ADDRESS (If rural give location): Route # 2

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Anne (Last) Mitchell

4. DATE OF DEATH: (Month) 6 (Day) 1 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1-12-1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months 4 Days 20 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Watha, Penda Co., N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Coston

14. MOTHER'S MAIDEN NAME: Phoebe Carroll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 214-28-1814

17. INFORMANT & ADDRESS: Mrs. Phoebe Smith, Parsonsburg, Md. Rt. # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart failure — Interval Between Onset And Death: 1wk.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertension — 1yr.
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 25 19 54 to May 31, 19 54, that I last saw the deceased alive on May 31, 19 54, and that death occurred at 3:15 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) Earl M. Leadley ADDRESS Pittsville Md DATE SIGNED June 3, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 6-7-'54

NAME OF CEMETERY OR CREMATORY Glass Hill Cemetery

LOCATION (City, town, or county) (State) Parsonsburg, Wicomico Co. Md.

DATE REC'D BY LOCAL REGISTRAR 6-5-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS Mary A. Stewart, 324 E. Church Street

STEWART FUNERAL HOME Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 8 1
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6021

Dr Saunders

6023 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico COUNTY Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wetipquin
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: Md STATE Wicomico Co COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wetipquin
STREET ADDRESS (If rural give location) Rural

3. NAME OF DECEASED: (Type or Print) (First) Eliza (Middle) A. (Last) Moore
4. DATE OF DEATH: (Month) June (Day) 30 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 2 Feb. 1885
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months 4 Days 28 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Wetipquin
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lemuel Moore
14. MOTHER'S MAIDEN NAME: Eliza Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: John Moore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Cardiac Failure. — Interval Between Onset And Death: 1 day.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Heart Disease. — 7 years.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inanition. — 1 week.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 March 1949, to 30 June, 1954, that I last saw the deceased alive on 30 June, 1954, and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE Richard H. Saunders (Degree or title) M.D. ADDRESS Nanticoke Md. DATE SIGNED 7/1/54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF July 3, 1954
NAME OF CEMETERY OR CREMATORY Odd Fellows Cem
LOCATION (City, town, or county) Wetipquin (State) Md
DATE REC'D BY LOCAL REGISTRAR 7-1-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Booker M. Webb ADDRESS Salisbury

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 19[illegible]4
BUREAU V[illegible] S[illegible]

6024 6022

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharptown
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home (Nanticoke Street)

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sharptown
STREET ADDRESS (If rural, give location) Nanticoke Street

3. NAME OF DECEASED: (Type or Print) (First) Marguerite (Middle) B. (Last) Mumford
4. DATE OF DEATH (Month) June (Day) 14 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	White	Married	5/10/08	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Housework	Kentucky	USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	266-30-8603	Mr. Vaughn Mumford; Sharptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (INTERVAL BETWEEN ONSET AND DEATH)

Immediate cause (a) Cerebral hemorrhage
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6/14/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6/16/54	Firemen's Cemetery	Sharptown-Wicomico-Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
6/15/54	Mary C. Owens	Floyd J. Smith, Sharptown, Md.

VS. A15A - 5 - 53

RECEIVED
JUN 17 1954
BUREAU V. S.

5998 MARYLAND STATE DEPARTMENT OF HEALTH 06023

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Dr. Rademaker

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, if especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 207 East Vine St.

3. NAME OF DECEASED (Type or Print): (First) NELLIE (Middle) MARIE (Last) NOCK

4. DATE OF DEATH: (Month) JUNE (Day) 18 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 4, 1919

9. AGE last birthday: 35 yrs. If under 1 year: Months / Days. If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: At own Home

11. BIRTHPLACE (State or foreign country): R.D. Eden Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Irving Thomas Johnson

14. MOTHER'S MAIDEN NAME: Nora Dryden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mr. Charles T. Nock (Husband) 207 E. Vine St

18. MEDICAL CERTIFICATION — Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Post partum hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured uterus (c) Shock

INTERVAL BETWEEN ONSET AND DEATH: 7 hours.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: 6-18-54

19b. MAJOR FINDINGS OF OPERATION: Ruptured uterus

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: J.A. Rademaker (Degree or title) ADDRESS: N. Division St. Salisbury, Maryland DATE SIGNED: June 19 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: June 20, 1954 — NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — LOCATION (City, town, or county) (State): Salisbury Maryland

DATE REC'D BY LOCAL REG.: 6-20-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

Walter R. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 86024

Dr. Beardsley 5999

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY: Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Salisbury~~ Parsonsburg
STREET ADDRESS (If rural give location): R.D. # 1

3. NAME OF DECEASED: (First) CHARLIE (Middle) RAYMOND (Last) PARKER

4. DATE OF DEATH: (Month) JUNE (Day) 24 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 14- 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months 4 Days 10 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired Lumberman & Farmer-Own Farm

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): R.D. # Millsboro Del

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abisha Parker

14. MOTHER'S MAIDEN NAME: Mary Truitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Millie S. Parker (Wife) R.D.# Parsonsburg Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset and Death: 5 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Chronic nephriti — 2 years
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 54, to June 24 1954, that I last saw the deceased alive on June 23, 1954 and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Paul W Beardsley MD
ADDRESS: E.Church St. Salisbury Maryland
DATE SIGNED: June 29 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: June 27,1954
NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
LOCATION (City, town, or county) (State): Salisbury Maryland

DATE REC'D BY LOCAL REGISTRAR: 6-25-54
REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 28
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06025

6000 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

Item 8 & 9 film G168 7/21/54 cm

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 Fooks St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 103 Fooks ST.

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) OTIS (Last) PARKS

4. DATE OF DEATH: (Month) June (Day) 21 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 1897 Sept. 18, 1898
9. AGE last birthday: 55 574 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: farmer
11. BIRTHPLACE (State or foreign country): Tompkinsville
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W. Parks
14. MOTHER'S MAIDEN NAME: Mary F. Bunting

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Mrs. Mazie M. Parks, 103 Fooks St. Salisbury Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of bladder DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 2 1/2 Years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953, to June 21, 1954, that I last saw the deceased alive on June 21, 1954, and that death occurred at 10 20 P.M., from the causes and on the date stated above.

SIGNATURE John M. Blossom III (Degree or title) M.D. ADDRESS 324 N. Division St., Salisbury, Maryland DATE SIGNED 6-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6/21/54
NAME OF CEMETERY OR CREMATORY Hearning
LOCATION (City, town, or county) Oak Hall (State) Va

DATE REC'D BY LOCAL REGISTRAR 6-1-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR J. H. Johnson Inc. ADDRESS Parksley, Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
1954
BUREAU V. S.

6025 06026

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 336

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar
LENGTH OF STAY (in this place) 62 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 E. Elizabeth St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Delmar
STREET ADDRESS (If rural, give location) 413 E. Elizabeth

3. NAME OF DECEASED: (Type or Print) (First) Elder (Middle) Francis (Last) Pippin
4. DATE OF DEATH (Month) 6 (Day) 5 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH: 9-3-1891
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Sussex County, Del
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Huggley Piffin
14. MOTHER'S MAIDEN NAME: Martha Callaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 716-01-9402
17. INFORMANT & ADDRESS: Mary Piffin - Delmar Del

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden Death

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) arteriosclerotic cardiovascular disease — 2 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none

19a. DATE OF OPERATION: none
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE J A Rademaker M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6-6-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6-7-1954
NAME OF CEMETERY ~~OR CREMATORY~~ Mt Olive
LOCATION (City, town, or county) (State) Delmar Del

DATE REC'D BY LOCAL REG. June 7 1954
REGISTRAR'S SIGNATURE Harry E. Hudson Sr
24. FUNERAL DIRECTOR W. S. Marvel Co - Delmar Del
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
JUN 9 1954
BUREAU V. S

Dr Ryan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06027

6001 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) R.D. # 3 Delmar Road

3. NAME OF DECEASED: (Type or Print) (First) LILLIE (Middle) MAE (Last) REINHARDT

4. DATE OF DEATH: (Month) June (Day) 20 (Year) 19 54

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Mar 18, 1916
9. AGE Last birthday: 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Co. Mgr. Singer
10b. KIND OF BUSINESS OR INDUSTRY: Machine Office
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nevin L. Welling
14. MOTHER'S MAIDEN NAME: Lillie Mae Malone

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mr. Frank G. Reinhardt(Husband) R.D.# 3 Delmar Rd. (Salisbury, Maryland)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Generalized Carcinomatosis — months

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Carcinoma of Cervix — 2 yrs
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20, 1954, to 6-20, 1954, that I last saw the deceased alive on 6-20, 1954, and that death occurred at 7.30 pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) Emil L Ryan M.D.
ADDRESS Camden Ave, Salisbury Maryland
DATE SIGNED June 22 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 23, 1954
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
LOCATION (City, town, or county) (State) Salisbury Maryland

DATE REC'D BY LOCAL REGISTRAR 6-22-54
REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR ADDRESS
HOLLOWAY & COMPANY SALISBURY MARYLAND
Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

JUN 24 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9/6028

6002 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY WICOMICO MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SALISBURY
LENGTH OF STAY (in this place) 12 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE DELEWARE COUNTY SUSSEX
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRANKFORD RURAL
STREET ADDRESS (If rural give location) [redacted]

3. NAME OF DECEASED: (Type or Print) (First) BRIGHT (Middle) L (Last) RICKARDS

4. DATE OF DEATH: (Month) JUNE (Day) 17 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 5/29/1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: + House Painting

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Washington Rickards

14. MOTHER'S MAIDEN NAME: Lila T. Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Elwood Rickards Selbyville Del.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarction, acute — Interval Between Onset And Death: 12 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic Coronary Thrombosis
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-5, 1954, to 6-17, 1954, that I last saw the deceased alive on 6-17, 1954, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William R. Ellis, Jr. MD ADDRESS Salisbury, Md. DATE SIGNED 6-17-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 6/19/54 NAME OF CEMETERY OR CREMATORY Rotana Cemetery LOCATION (City, town, or county) (State) Rotana Delaware

DATE REC'D BY LOCAL REGISTRAR 6-18-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Watson & Grey ADDRESS Frankford Delaware

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 21 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6029

6026 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Maggie (Middle) Ella (Last) Selby

4. DATE OF DEATH: (Month) June (Day) 3 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 23, 1884

9. AGE Last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Mardela Springs, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Brown

14. MOTHER'S MAIDEN NAME: Sarah Winder

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mary Capes, Delmar, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Renal failure with arteriosclerotic Nephritis — 1 wk.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c) Hypertensive cardiovascular disease — 6 years +

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronal Thrombosis — 6 years

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1950, to death, 19 ..., that I last saw the deceased alive on 6/3 ..., 19 54, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ernest R. Farmer M.D. ADDRESS Delmar Del DATE SIGNED 6/5/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 7, 1954

NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery

LOCATION (City, town, or county) (State) Near Delmar, Delaware

DATE REC'D BY LOCAL REGISTRAR 6-7-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS J.J. Frampton and Son, Federalsburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 9 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6030

6003 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 512 Mitchell

3. NAME OF DECEASED: (First) (Middle) (Last) Smullen
4. DATE OF DEATH: (Month) June (Day) 4 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: June 4-1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 7 9
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Wilmer Allen Smullen
14. MOTHER'S MAIDEN NAME: Missouri Ellen Raborn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

7768
Immediate cause (a) Prematurity
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-4 ....,1954, to 6-4- ....., 1954, that I last saw the deceased alive on 6/4 ....., 1954, and that death occurred at 12:19 pm from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Andrew C Mitchell, MD 228 N Division Salisbury md 6/7/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 6-7-54. NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) (State) Salisbury, Wicomico Maryland

DATE REC'D BY LOCAL REGISTRAR 6-7-54 REGISTRAR'S SIGNATURE Mary M. Holloway 24. FUNERAL DIRECTOR Peninsula General Hospital ADDRESS

2064244301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06031

6004 **CERTIFICATE OF DEATH** Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury, Maryland

LENGTH OF STAY (in this place) 7 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Kent

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall, Maryland

STREET ADDRESS (If rural, give location) --

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) Stevens

4. DATE OF DEATH: (Month) June (Day) 23 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Feb. 23, 1883	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Kent County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. D. Stevens

14. MOTHER'S MAIDEN NAME: Emma Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) --

16. SOCIAL SECURITY NO.: 213-22-5083

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (Final disease or condition resulting in death)	(a) Squamous cell Ca. of base of tongue c. advanced DUE TO	approx. 1 year
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) metastasis to neck, lungs & cervical spine. DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 17 1954, to June 23 1954, that I last saw the deceased alive on June 23, 1954, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Dr. L Sherman M.D. Deers Head Hospital 6/23/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	6/27/54	Wesley Chapel	Rock Hall	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-24-54	Mary W. Holloway	Elgar T. Lane	Church Hill, Md.

RECEIVED
JUN 28 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06032

6005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 536 Winder St.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Gordon (Last) Stewart

4. DATE OF DEATH: (Month) June (Day) 19 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 2, 1886
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR Months 2 Days 17 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Employee of Farmers & Planters Co.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): R.D. Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Stewart
14. MOTHER'S MAIDEN NAME: Elizabeth Williams

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mrs. Wilsie V. Stewart (Wife) 536 Winder St Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset And Death: 3 months

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of pancreas — 3 months

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19...., that I last saw the deceased alive on ....., 19....., and that death occurred at 1 pm, from the causes and on the date stated above.

SIGNATURE J A Rodemeier (Degree or title) ADDRESS Camden Ave. Salisbury, Maryland DATE SIGNED June 23 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 23, 1954
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
LOCATION (City, town, or county) (State) Salisbury Maryland

DATE REC'D BY LOCAL REGISTRAR 6/25/54
REGISTRAR'S SIGNATURE Mary Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 25 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6033

Dr. Sohlar

6027 CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R. D. # 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury Rural
STREET ADDRESS (If rural give location): R. D. # 4

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) ARTHUR (Last) TILGHMAN

4. DATE OF DEATH: (Month) JUNE (Day) 18 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 22, 1882

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: On Own Farm

11. BIRTHPLACE (State or foreign country): R. D. # Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Tilghman

14. MOTHER'S MAIDEN NAME: Martha Adkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Mamie Perdue Tilghman (Wife) R.D.# 4

18. MEDICAL CERTIFICATION — Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Liver — Interval Between Onset And Death: 2 months

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis generalized — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 19 54, to June 18, 19 54, that I last saw the deceased alive on June 16 19 54, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. V. Sohler M.D. ADDRESS Delmar, Maryland DATE SIGNED June 19 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 21, 1954

NAME OF CEMETERY OR CREMATORY Parsonsburg Cemetery

LOCATION (City, town, or county) (State) Parsonsburg, Maryland

DATE REC'D BY LOCAL REGISTRAR 6-20-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

VS. A15

RECEIVED
JUN 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19 6034

CERTIFICATE OF DEATH

6006

Reg. Dist. No. 332

1. PLACE OF DEATH: Deer's Head State Hospital
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury, Md.
LENGTH OF STAY (in this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2101 W. Cold Spring Lane

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) -- (Last) Turner

4. DATE OF DEATH: (Month) June (Day) 6 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: ? 1875

9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Near Cambridge, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown (If Yes, give war or dates of service) --

16. SOCIAL SECURITY No.: --

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Recurrent cerebral thrombosis — Interval Between Onset and Death: 3 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arteriosclerosis general — ?

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 2

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3, 1953, to 6-6, 1953, that I last saw the deceased alive on 6-6, 1953, and that death occurred at 1:35 P.m., from the causes and on the date stated above.

SIGNATURE Dr. Guerman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head State Hospital, Salisbury, Md. DATE SIGNED 6.6.54

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF June 9 1954 — NAME OF CEMETERY OR CREMATORY Anatomical Bd — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. 6-9-54 — REGISTRAR'S SIGNATURE Mary W Holloway

24. FUNERAL DIRECTOR Barker M. Webb — ADDRESS Salisbury, Md.

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6035

6007

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9 film G168 7/21/54 cm

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 705 Collins Street

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) (Last) Turner

4. DATE OF DEATH: (Month) June (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug 11 1908

9. AGE last birthday: 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Quantico, md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Noah Bell

14. MOTHER'S MAIDEN NAME: Biddie Wright

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Leucopenia — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) — DUE TO

(c)

Interval Between Onset And Death: 1 week

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... ,19 ..... to ..... , 19 ..... , that I last saw the deceased alive on 6-30, 19 54, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

SIGNATURE: William R. Ellis Jr. MD (Degree or title) — ADDRESS: Salisbury, Md — DATE SIGNED: 6-30-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 3 1954 — NAME OF CEMETERY OR CREMATORY: Green Acres — LOCATION (City, town, or county) (State): Salisbury Md

DATE REC'D BY LOCAL REGISTRAR: 7-1-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: Booker and Wicks — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 1954
BUREAU V. I

6008 06036

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 732 Dennis St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury

STREET ADDRESS (If rural, give location) 732 Dennis St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James		Wainwright	6	5	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	Colored	Married	Oct. 18, 1915	38 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dispatcher	None	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Conway	Elizabeth Wainwright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	578-18-3895	Bertha Wainwright

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE J. A. Rademacher M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 6/5/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-8-54	White Haven Cem.	White Haven Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-8-54	Mary M. Holloway	Booker M. Veach	Salisbury Md.

RECEIVED
JUN 11 1954
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6037

6009 CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Wicomico

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Salisbury

MARYLAND LENGTH OF STAY (in this place) 2 wks.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

STREET ADDRESS (If rural give location) Oaks

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	Robert	Fulton	Waller	6	4	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	DEC. 12, 1886	68 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Not Contractor	Building Cont.	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Benjamin F. Waller	Frances Wingate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
W.W.I W.W.I	217-10-3997	Mrs. R. Fulton Waller - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Generalyzed Arteriosclerosis

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Cholecystitis

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5-13-54	Acute cholecystitis + cholelithiasis	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to 6-4, 1954, that I last saw the deceased alive on 6-4, 1954, and that death occurred at 2:50 P.M. from the causes and on the date stated above.

SIGNATURE Philip A. Tuohy M.D. (Degree or Title) ADDRESS Salisbury Md DATE SIGNED 6-5-54

23. BURIAL, CREMATION, REMOVAL: (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6/6/54	Parsons Cemetery	Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-6-54	Mary W. Holloway	The Hill & Johnson Co.	Salisbury, Md.

George C. Hill II

VS. A15

RECEIVED
JN 8 1954
BUREAU V. S.

Film G169. Item 6010, 8-23-54, et

07033

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY: Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury

LENGTH OF STAY (in this place): 1½

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Virginia — COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Chincoteague

STREET ADDRESS (If rural, give location): N. Main Street

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)
Warren Watson	June 8 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Sept 23, 1933	20 yrs. 8 m. 11 d.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waterman	Oyster	Chincoteague, Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Watson	Mary Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS
		Mrs. Lucille Baylis, Chincoteague, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chest injuries: 3 frac. ribs; punctured	7½ hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) lungs, lacerated liver	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
None		Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
		½ mile south of Naval base in Chinco.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR?
June 8, 54 10:30 M.		truck. sand caved in on him when loading

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. R. Ademuske — M. D. — CHIEF MEDICAL EXAMINER / DEPUTY MEDICAL EXAMINER / ASSISTANT MEDICAL EXAM. — DATE SIGNED: 7-14-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	8-11-54	Thornton Cemetery	Chincoteague Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-14-54	Mary M. Holloway	Wm. B. Salyer	Chincoteague, Va.

JUL 13 1934

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06039

Dr. Hurdle 6011 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) Since 9/9/48
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital Salisbury, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury, Md.
STREET ADDRESS (If rural give location) 209 Bond St.

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Wootman (Last) White

4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1954

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 18, 1883

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Whitesville, Del.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eli White

14. MOTHER'S MAIDEN NAME: Cordelia Hearne

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNK (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-05-3467

17. INFORMANT & ADDRESS: Patient when admitted & Mr. John Tilghman Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO Chronic Myocarditis — Interval Between Onset And Death 2yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Pulmonary Tuberculosis arrested — 6 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9/9, 1948, to 6/2/, 1954, that I last saw the deceased alive on 6/2 1954, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
L. M. Hurdle M.D., Supt. Salisbury, Md. 6/2/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF June 5, 1954 NAME OF CEMETERY OR CREMATORY Parsonsburg Cemetery LOCATION (City, town, or county) (State) Parsonsburg, Maryland

DATE REC'D BY LOCAL REGISTRAR 6-3-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS
HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 7 1954
BUREAU V. S.

Film#G167 Item# 9
6/24/54 emf

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06040

6012 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill 23X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Dock (Middle) (Last) Williams

4. DATE OF DEATH: (Month) June (Day) 16 (Year) 1954.

5. SEX: Male
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 11-3-1880.
9. AGE last birthday: 73 7/4 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Raliegh North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: no Record.
17. INFORMANT & ADDRESS: Mrs Sara Blaine

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral arteriosclerosis — Interval Between Onset And Death: unknown

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis — "

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-13, 1954, to 6-16, 1954, that I last saw the deceased alive on 6-16, 1954, and that death occurred at 3:25 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Willem R. Ellis Jr. MD
ADDRESS Salisbury, Md.
DATE SIGNED 6-16-54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF June 17, 1954
NAME OF CEMETERY OR CREMATORY Anatomical Board
LOCATION (City, town, or county) (State) Balto City Md.

DATE REC'D BY LOCAL REGISTRAR 6-17-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Barker McCrest
ADDRESS Salisbury Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 21 1954
BUREAU V. S.

06041

MARYLAND STATE DEPARTMENT OF HEALTH

6028 2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Worcester MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke / LENGTH OF STAY (In this place) 19 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke /
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St	STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ida	Elizabeth	Wilson	6	1	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	5-30-1875	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	—	Worcester County Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Handy Graham	Virginia Hurley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Samuel J. Wilson Pocomoke Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (#42X)	(a) Uremia due to Chronic Nephritis	1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	5yrs +
	(c) Senility	5yrs +
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from ....., 1945, to June 1, 1954, that I last saw the deceased alive on May 30, 1954, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
William C Harrison MD	Hurlock Md	6/1/54

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-3-1954	Pocomoke	Pocomoke, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 2 1954	Harry E. Hudson Sr	W. S. Ingram Co - Selma, La	

RECEIVED
JUN 7 1954
BUREAU V. S.